BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

JANET M. MASCHINO Claimant	)	
V.	)	
	)	Docket No. 1,042,977
MERCY HEALTH SYSTEM OF KS, INC. Self-Insured Respondent	)	

ORDER

Respondent requested review of the May 8, 2015 Award by Administrative Law Judge (ALJ) Brad E. Avery. The Board heard oral argument on November 3, 2015.

APPEARANCES

Kala Spigarelli, of Pittsburg, Kansas, appeared for the claimant. Joseph R. Ebbert, of Kansas City, Missouri, appeared for self-insured respondent.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The ALJ found claimant to be permanently and totally disabled by virtue of the presumption she is not capable of substantial and gainful employment after her accidental injury. The ALJ ordered respondent to pay claimant's medical bills associated with claimant's lymphedema and cellulitis.

Respondent appeals, arguing the Board should reverse the Award and find claimant is not permanently and totally disabled. Respondent argues the ALJ misapplied the presumption from *Casco* and should have placed the burden upon claimant to prove she was permanently and totally disabled. Respondent contends the Award should be limited to permanent partial disability. Respondent also asks for clarification as to the specific amount owed by respondent in regard to outstanding medical expenses in the record.

Claimant contends the Award should be affirmed.

The issues on appeal are:

1. Is claimant permanently and totally disabled as a result of the March 17, 2008, accident?

2. Did the ALJ erroneously order medical benefits to be paid in regard to Exhibit 4 to Dr. Dunn's deposition? If so, how much medical is due and owing?

FINDINGS OF FACT

Claimant, a registered nurse since 1979, testified she began working for Mercy Health System of Kansas (respondent) in May 2000. At the time of her deposition, claimant was working through respondent at Pleasanton Family Practice for Jay Allen, M.D.

Claimant's work duties included drawing labs, performing EKGs, starting IVs, processing blood specimens, placing patients in the exam room, making and returning phone calls, refilling medications and whatever else needed to be done. Part of claimant's job also involved going to the local adult care facilities to do blood draws and pick up lab samples. Claimant also occasionally went to the parking lot to attend to individuals who had trouble getting in the building.

On March 17, 2008, claimant slipped and fell on a wet spot and landed hard on her left knee. As claimant was falling, she used her left arm to grab onto a refrigerator handle and, as she went down, her arm was pulled out of the socket. Claimant had immediate pain in her left knee and left shoulder. Claimant's boss, Dr. Allen, and Teresa Hall, one of the other nurses, came to her aid. Despite her pain, claimant returned to work and completed the work day because they were very busy.

The next day, March 18, 2008, Dr. Allen examined claimant and created a medical record. Claimant indicated she injured her left knee, left shoulder and left arm. In his March 18, 2008, office note, Dr. Allen noted claimant fell the day before and likely had a soft tissue injury. He wrote he was witness to claimant's accident and that claimant hurt her left shoulder and left kneecap. He was going to perform an exam on the day of the accident, but they were busy and forgot when claimant did not push the issue. The next day, when Dr. Allen did perform an examination of claimant, he found crepitace in claimant's left shoulder. He noted claimant was able to go through passive range of motion, but was unable to extend her hand completely above her head. He ordered conservative treatment, anti-inflammatory medication and topical heat. He opined if claimant was not significantly improved in 7 to 14 days, he would consider imaging studies.

The next office note from Dr. Allen was dated September 27, 2008, and indicated claimant complained of knee pain that has bothered her since her March fall. Dr. Allen injected claimant's knee with lidocaine and kenalog and she had immediate improvement in her symptoms. An MRI was scheduled for the left knee and left shoulder.

Claimant continued to see Dr. Allen periodically for her injuries, but there are few office notes from claimant's visits with Dr. Allen because claimant was his nurse and a lot of the time they would just talk. Claimant indicated that, although x-rays were prescribed, she never had them because she has been exposed to a lot of radiation with her thyroid condition, Graves disease and previous breast cancer, and she did not want to be exposed to any additional radiation. Claimant took over-the-counter pain medication until September 2008, when she received her first steroid injection.

Claimant met with board certified orthopedic surgeon William L. Dillon, M.D., on October 7, 2008, at Labette Health and underwent an MRI[1] of her left knee and left shoulder. Claimant reported persistent and severe knee pain and difficulty ambulating. Dr. Dillon found crepitus in claimant's knee with significant leg swelling and pain on movement of the patella along the medial joint compartment. X-rays revealed degenerative changes with osteophyte formation and medial joint space narrowing. The MRI revealed degenerative disease in the patellofemoral joint and medial joint compartment. Claimant opted for conservative treatment.

Claimant underwent a series of knee injections (Synvisc) under the care of Dr. Dillon. The focus of her treatment with Dr. Dillon was her left knee, as it was the most painful. Claimant testified respondent was aware of her treatment at Labette Health. Claimant testified she went to Labette Health because she felt no one at respondent was trying to help her and she had reached the point where she was unable to put weight on her leg to walk. Claimant began using crutches to ambulate in September 2008, after her first injection. Claimant denied prior left knee, left shoulder or arm problems. Claimant testified that, although Dr. Dillon gave her an off work slip which she presented to respondent, respondent asked her to continue to work and she agreed.

Dr. Dillon became claimant's authorized treating physician on February 10, 2010, pursuant to the Order of the ALJ. The initial authorization was for the treatment of claimant's right knee. Claimant underwent a left knee replacement on April 12, 2010, and an August 30, 2010, right knee replacement. Dr. Dillon indicated claimant aggravated her right knee condition by favoring her left knee and the way she was having to walk due to her injury at work. Dr. Dillon last saw claimant on September 9, 2010, for followup on the August 30, 2010, right knee replacement. Dr. Dillon indicated claimant had restrictions for her left knee, but they would not have prevented her from doing sedentary to light sedentary work. He felt claimant's right knee was the reason she was not able to return to work.

[1] Claimant obtained the MRI on her own with Dr. Dillon because respondent refused to pay for one.

Dr. Dillon determined the swelling claimant had in her lower extremities was lymphedema.[2] Dr. Dillon was aware claimant had lymphedema prior to the 2008 accident. He determined claimant's current lymphedema had been aggravated by the accident and claimant being sedentary following the knee surgery. This current condition was not related to lymph nodes claimant previously had removed from her arm due to cancer.

During his treatment of claimant, he noted problems with claimant's left shoulder. Dr. Dillon testified claimant was using a walker, which did not help her shoulder. He recommended land and aquatic therapy for her knees.

Dr. Dillon indicated nothing would be done about claimant's shoulder until she is independent without a walker, crutch or cane. Regarding claimant's knees, he testified:

> Q. Is it your testimony, Doctor, that the right knee that you performed the replacement surgery on was due to the initial trauma in 2008 or something else that occurred after that time?
>
> A. No, I can't say that. I -- the only thing I can say and if I was in Court --
>
> Q. Well, you are kind [of] in Court now so --
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> A. I know, I know that, but I mean if I had to testify in front of a jury, would be that certainly the degenerative process in her right knee was aggravated by what she had to go through before she got her left knee done.
>
> Q. So it wasn't so much the 2008 accident but it is her -- the way she was walking after the -- after the left knee injury in 2008?
>
> A. Yes.
>
> Q. And it is your opinion within a reasonable degree of medical probability that -- that altered walking method was having impact upon the right knee?
>
> A. Yes.[3]

Claimant was restricted to sitting 95 percent of the day with four, five-minute breaks. With this restriction, claimant experienced tremendous back pain. When claimant started having swelling in her legs and abdomen, the lymphedema was diagnosed, which was caused from the sitting. Claimant had to be hospitalized for the lymphedema because she developed shortness of breath. Claimant has undergone therapy for the lymphedema.

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[2] Lymphedema is a congenital condition where the lymph tubes do not drain fluid out of the body like they should, which causes a lot of swelling.

[3] Dillon Depo. at 25-26.

Claimant has been off work since January 11, 2008, at the order of Dr. Barnthouse. Dr. Barnthouse recommended she see a neurosurgeon for her back.

Since the accident, claimant cannot stand for long periods of time, even with crutches. She testified that if she stands for more than a minute or two she has tremendous pain. She cannot do housework or go grocery shopping. Claimant denies any prior workers compensation claims, but admits to a prior injury where an accident report was made, but no claim was pursued. Claimant testified that sometime in 2005 or 2006, her right knee popped as she tried to run down a ramp to pull a patient up before she tumbled out of her wheelchair. Claimant had a x-ray which revealed a torn meniscus. She was given a knee brace to wear with the hope it would get better and it did.

In the incident report from the current accident, claimant indicated injury to her left shoulder and left knee. There was no mention of her back at the time, but she alleges she had injured that as well. She noticed the back pain shortly after the incident report was filled out. Initially, the focus was on claimant's left knee as it was bothering her the most. Claimant attributes her back pain to her altered gait because of her knee.

Claimant indicated she has gained at least 100 pounds since the accident, 30 of those she felt were from the accident and the other 70 from fluid related due to the lymphedema. Claimant testified she never had the back pain that she has now until the March 2008 fall. Claimant had not had any formal treatment for her left shoulder. The belief was that her knee should be taken care of before dealing with her shoulder and back.

At the time of the regular hearing, claimant had undergone the arthroscopy and total knee replacement with Dr. Dillon. She had injections in her left shoulder and surgery was suggested, but not performed. Claimant testified she uses a walker, a cane or has her husband help her ambulate. She needs this help because of the lymphedema and her back pain.

Claimant physically last worked for respondent in January 2009. Claimant's employment with respondent was terminated in 2010 after her right knee replacement. Claimant indicated she was not able to return to work after her knee replacements even in a seated capacity because of her lymphedema and back pain. Claimant is collecting Social Security Disability.

Claimant is only able to walk fifteen feet and that is with tremendous pain. She is unable to sit for long periods of time. Claimant testified she has such swelling in her legs and feet from the lymphedema that she has to wear wide width men's shoes.

Claimant did not realize she had been diagnosed with hyperlipidemia prior to the accident. She also indicated the first time she began to experience swelling related to the March 2008 accident, was shortly after she was assigned to desk work. Claimant got

worse from that point on. Claimant indicated she met with Dr. Dunn and Dr. Dillon regarding the lymphedema and was provided treatment.

Claimant uses a walker for walking longer distance and a cane for shorter distances. Claimant indicated the walker is for her back pain and she had it before her knee surgeries. Claimant indicated her unsteadiness would keep her from returning to work.

At the request of her attorney, claimant met with board certified orthopedic surgeon Edward J. Prostic, M.D., on November 3, 2009, for an examination. Claimant's greatest area of concern was her low back, with pain across her back at waist level and below and with radiation into her left thigh where she experiences numbness. Claimant has difficulty when awakening and is worse with all activities. She also had, in the front of her left knee, pain on a constant basis and an ache from her left shoulder to her hand. Claimant's knee and shoulder pain are worse with activity. At the time of this first examination, claimant weighed 270 pounds.

Dr. Prostic determined claimant needed a left knee replacement and opined no treatment for the low back would be beneficial until her knee was comfortable. He also felt claimant had irritation of her rotator cuff and felt that would not go away until she no longer needed walking aids. It was Dr. Prostic's opinion that the fall caused the injury to claimant's knee, shoulder and back. He felt claimant was limited to predominately sedentary activities at work.[4]

Claimant was reevaluated by Dr. Prostic on October 29, 2013. Dr. Prostic noted claimant had undergone successful bilateral knee replacements, but continued to have difficulties with her shoulder and low back, with no significant treatment provided to those areas. Claimant had not worked since 2009, and her weight had increased to 346 pounds. Claimant's greatest concern at this time was her low back, reporting pain in the center and right side of her back below the waist, with numbness and tingling in both thighs. Her pain was worsened by being on her feet. She had lymphedema in both legs and pain from her left shoulder to her left elbow with clicking and popping and an inability to reach behind her.

Dr. Prostic examined claimant and opined she sustained numerous injuries in a fall during the course of her employment. He noted claimant has chronic low back difficulties and apparent rotator cuff dysfunction of the left shoulder. Dr. Prostic anticipated no improvement to the shoulder or low back unless claimant could gain control of her depression and become more fit. He testified claimant's weight contributed to the acceleration of right knee problems. He indicated that if claimant lost weight it would decrease her chances of needing revision surgery for her knees and reduce further shoulder problems because using a walking aid places an extra burden on her shoulders. He did not think weight loss would affect claimant's low back because she did not have an

[4] Prostic Depo., Ex. 2 at 3 (Dr. Prostic's November 2, 2009, report).

indication of back surgery even if she were slender. She does not have radiculopathy, spinal stenosis or instability. The only problems with claimant's back are degenerative, aggravated by poor conditioning.[5]

Dr. Prostic assigned the following functional impairments: 10 percent to the left upper extremity; 15 percent of the body as a whole for the lumbar spine; and 37 percent of the left lower extremity, for a combined functional impairment of 32 percent to the whole body. Ultimately, Dr. Prostic found claimant to be permanently and totally disabled from gainful employment.[6]

In a letter dated April 18, 2014, Dr. Prostic added a 15 percent functional impairment to the left lower extremity for lymphedema requiring the use of a compression machine, compression stockings and wraps. His ratings are pursuant to the 4th Edition of the AMA *Guides*. In reviewing the task list of Jerry Hardin, Dr. Prostic opined claimant has an 80 percent task loss having lost the ability to perform 44 out of 55 tasks.

Royce E. Dunn, D.O., a board certified internal medicine physician with Olathe Medical Services, testified claimant has been one of his patients since 2004. He saw her regularly from 2004 to 2006 and then again until early 2010.

Claimant met with Dr. Dunn on January 26, 2010, with a number of complaints. Her weight had increased, she had increased leg swelling, poor mobility, and shortness of breath with activity. Dr. Dunn diagnosed claimant with lymphedema. She was admitted to the hospital for evaluation to make sure she didn't have congestive heart failure and to drain the fluid. The hospitalization, in the doctor's opinion, was reasonable and necessary at the time of the admission.

Dr. Dunn testified that even though claimant had lymphedema previously in 2006, the lymphedema she presented with in 2010 was different in nature and was brought on by a specific event. He testified if claimant was going to have lymphedema from her breast cancer surgery it would be in her right arm and not her legs.[7] However, the medical records indicate claimant suffered from lymphedema in 2006 involving her legs, which the doctor speculated was from obesity.[8] In Dr. Dunn's opinion, claimant's lymphedema and resulting weight gain in 2010, occurred as the result of her work-related accident and resulting medical conditions. Dr. Dunn acknowledged that lymphedema is not usually

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[5] *Id.* at 27.

[6] *Id.*, Ex. 3 at 2 (Dr. Prostic's October 29, 2013, report).

[7] Dunn Depo. at 38.

[8] *Id.* at 40,46.

curable. It is a condition that can only be managed with treatment. Claimant was discharged on January 28, 2010.

Claimant asserts she continues to suffer from this chronic condition. Dr. Dunn indicated the lymphedema claimant had when he saw her in 2010 was due to her work restrictions and the inactivity associated with those restrictions. He also agreed claimant's weight gain had been caused by her lymphedema. He described this as a cycle. Claimant would gain weight as a result of the lymphedema which would then cause her lymphedema to worsen, causing claimant to be less active, leading to greater weight gain. He testified he knew of claimant's knee injury but nothing of her back and shoulder problems. Dr. Dunn indicated that although claimant had shoulder and neck complaints, he did not treat those areas.

Claimant was hospitalized again on September 11, 2010, for cellulitis in her right leg, which he determined was a common complication of surgery. The treatment provided was, in Dr. Dunn's opinion, reasonable and necessary treatment due to the fact claimant would not respond to oral antibiotics. She would need intravenous antibiotics to treat that infection successfully. Claimant was in the hospital from September 11, to September 15, 2010. Dr. Dunn testified diuretics and compression therapy would be the recommended long-term treatment for the lymphedema.

Dr. Dunn was provided a list of expenses associated with claimant's admission to the hospital on September 11, 2010, marked as Exhibit 4. The doctor was asked whether the charges contained in that exhibit were, as far as he could tell, from that admission. He answered in the affirmative. Respondent objected to the bills as lacking proper foundation. Additional foundation for those medical bills was not provided. This record does not indicate when, if at any time, Dr. Dunn was authorized by either respondent or the ALJ.

Dr. Dunn indicated he did not feel claimant was able to return to the nursing work she did before. Her ability to do other work would depend on the work.

Claimant met with Paul S. Hardin, via telephone for a task assessment on November 22, 2013. Mr. Hardin wrote it was his opinion after considering Dr. Prostic's October 29, 2013, report, that claimant is essentially and realistically unemployable. He felt claimant is unable to obtain or perform substantial, gainful employment and noted she has been on Social Security Disability since 2011.

PRINCIPLES OF LAW AND ANALYSIS

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.[9]

K.S.A. 2007 Supp. 44-501(a) states:

> (a) If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act. In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2007 Supp. 44-508(g) states:

> (g) ''Burden of proof'' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.

K.S.A. 44-510c(a)(2) (Furse 2000) states:

> (2) Permanent total disability exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, or both legs, or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis, or incurable imbecility or insanity, resulting from injury independent of all other causes, shall constitute permanent total disability. In all other cases permanent total disability shall be determined in accordance with the facts.

The ALJ found claimant to be permanently and totally disabled as the result of the accident on March 17, 2008. The Board agrees. Claimant suffered injuries to her left knee and shoulder at the time of the accident. She then developed right knee and low back difficulties resulting from her altered gait and weight gain. The weight gain stemmed from the development of lymphedema in her lower extremities which was caused or aggravated by the work injuries and very limited activity levels after the accident. Those limited activities were directly tied to claimant's significant restrictions which rendered her sedentary a good deal of the time.

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[9] *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

When a primary injury under the Workers Compensation Act arises out of and in the course of a worker's employment, every natural consequence that flows from that injury is compensable if it is a direct and natural result of the primary injury.[10]

In workers compensation litigation, it is not necessary that work activities cause an injury. It is sufficient that the work activities merely aggravate or accelerate a preexisting condition. This can also be compensable.[11]

Respondent contends claimant's lymphedema was a preexisting condition and it should not be responsible for the care and treatment of same. However, both Dr. Dillon, one of claimant's authorized treating physicians, and Dr. Dunn agreed claimant's lymphedema was aggravated by the accident and resulting conditions displayed by claimant. The Board finds claimant suffered the accident to her left knee and left shoulder, later developed problems in her right knee and low back, and also aggravated her lymphedema, making the condition much worse than that displayed in 2006.

Claimant has satisfied her burden of proving she is permanently and totally disabled as the result of the work accident and subsequent physical problems which developed thereafter. The medical opinion of Dr. Prostic and the vocational opinion of Mr. Hardin are found persuasive on this issue. The Award of the ALJ is affirmed on this issue.

K.S.A. 2007 Supp. 44-510h(a)(b)(2) states:

> (a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515 and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.
> (b) (1) . . .
> (2) Without application or approval, an employee may consult a health care provider of the employee's choice for the purpose of examination, diagnosis or treatment, but the employer shall only be liable for the fees and charges of such health care provider up to a total amount of $500. The amount allowed for such examination, diagnosis or treatment shall not be used to obtain a functional impairment rating. Any medical opinion obtained in violation of this prohibition shall not be admissible in any claim proceedings under the workers compensation act.

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[10] *Gillig v. Cities Service Gas Co.*, 222 Kan. 369, 564 P.2d 548 (1977).

[11] *Harris v. Cessna Aircraft Co.*, 9 Kan. App. 2d 334, 678 P.2d 178 (1984).

Under the Kansas Workers Compensation Act (Act), an employer is responsible for providing medical treatment necessary to cure and relieve the employee from the effects of a work-related injury.[12] This obligation extends to any aggravations of preexisting conditions as well as any natural consequences of the original injury. In this instance, respondent supplied claimant with medical treatment after the original injury and later when her knee and shoulder did not heal. Dr. Dillon was the authorized treating physician and performed replacement surgery on both of claimant's knees. He also examined her shoulder and was her treating physician when claimant was diagnosed with lymphedema in her lower extremities.

Dr. Dunn, however, was not authorized to treat claimant. In *Saylor,* the respondent was ordered to pay for the claimant's knee replacement after it was determined Westar had knowledge of *Saylor's* work-related injury and refused or neglected to provide medical treatment for that injury. The $500.00 statutory limitation was not applied in that instance.

However, in *Thompson,*[13] an unpublished opinion, the Board reversed in part an Award by the ALJ which prohibited payment in excess of the $500.00 statutory unauthorized medical maximum. The Court of Appeals reversed the Board, finding the respondent in *Thompson* had provided authorized medical treatment to the claimant and rejected the argument that emergency medical treatment would allow the claimant to avoid the medical limitations for unauthorized medical care. *Thompson* was limited to the statutory $500.00 limit even with unauthorized emergency room treatment.

Here, when claimant was examined and treated by Dr. Dunn in January and September in 2010, it was without respondent's authorization and without an order from the ALJ. While Dr. Dunn testified the treatment on both occasions was reasonable and necessary, without authorization, his treatment is limited under K.S.A. 2007 Supp. 44-510(h) to $500.00. The ALJ ordered respondent to pay for the entirety of claimant's treatment under Dr. Dunn. The Award is reversed on this issue and claimant is limited to the statutory unauthorized maximum medical payment.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be affirmed in part and reversed in part. Claimant satisfied her burden of proving she is permanently and totally disabled as the result of the accident on March 17, 2008, but the medical treatment provided by Dr. Dunn in January and

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[12] *See Saylor v. Westar Energy, Inc.*, 292 Kan. 610, 256 P.3d 828 (2011).

[13] *Thompson v. Hasty Awards, Inc.*, No. 106,359, 2012 WL 1970241 (unpublished Kansas Court of Appeals opinion filed May 25, 2012).

September 2010, is found to be unauthorized medical treatment and claimant is limited to the statutory maximum of $500.00.

The record does not contain a filed fee agreement between claimant and his/her attorney. K.S.A. 44-536(b) mandates that the written contract between the employee and the attorney be filed with the Director for review and approval. Should claimant's counsel desire a fee be approved in this matter, he/she must file and submit his/her written contract with claimant to the ALJ for approval.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Brad E. Avery dated May 8, 2015, is affirmed in part and reversed in part as above set out. In all other regards, the Award of the ALJ is affirmed insofar as it does not contradict the findings and conclusions contained herein.

IT IS SO ORDERED.

Dated this _____ day of December, 2015.

_____
BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

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